

# REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 2-A-09

Subject: Financial Barriers to Health Care Access  
(Resolution 704, I-07)

Presented by: Regina M. Benjamin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(Daniel W. Van Heeckeren, MD, Chair)

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1 Resolution 704 (I-07), introduced by the Colorado Delegation, and referred by the House of  
2 Delegates (HOD), asked our American Medical Association (AMA) to recognize that providing  
3 adequate health care is a fundamental societal obligation. The Council on Ethical and Judicial  
4 Affairs testified that it was currently considering the issue. The following report presents the results  
5 of the Council's analysis and deliberations.

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7 Health care can be viewed as a fundamental human good because it affects "our opportunity to  
8 pursue life goals, reduces our pain and suffering, prevents premature loss of life, and provides  
9 information needed to plan our lives."<sup>1,2</sup> AMA's *Principles of Medical Ethics* set out physicians'  
10 ethical obligation to support access to medical care for all people (Principle IX),<sup>3</sup> an obligation that  
11 physicians share with all who are involved in providing and financing health care, including the  
12 medical profession as a whole, health care facilities and payers, and public policymakers. Yet lack  
13 of health insurance and inability to pay out of pocket mean that many individuals do not have  
14 access to care.

15  
16 This report examines financial barriers that prevent individuals from getting care and the ethical  
17 responsibility that physicians, individually and as a profession, have to ensure that all individuals  
18 can access needed care regardless of their economic status. Although financial barriers to access  
19 are only one of several factors that affect patients' health and well-being, they are a significant  
20 concern and one that physicians and the profession can take steps to address. The Council on  
21 Ethical and Judicial Affairs anticipates addressing other barriers to care in future reports.

## 22 23 THE IMPACT OF FINANCIAL BARRIERS TO ACCESS

24  
25 Since the middle of the 20th century, a variety of steps have been taken to promote greater access  
26 to health care, including tying funding for the building and modernization of hospitals under the  
27 Hill-Burton Act to provision of charity care, mandating care in emergency situations through the  
28 Emergency Medical Treatment and Active Labor Act, and establishing Medicare, Medicaid, and  
29 the State Children's Health Insurance Program (SCHIP) to provide medical care to potentially  
30 vulnerable groups (children, the poor, the elderly, and persons with disabilities). Providing charity

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\* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 care has historically been an important mission of many religious institutions, such as the Catholic  
2 Health Association, and recognized as an ethical obligation by the medical profession, for example,  
3 through the *Principles of Medical Ethics* as well as public policy initiatives, such as the AMA’s  
4 “Health Policy Agenda for the American People” in the mid-1980s or current “Campaign for the  
5 Uninsured.”

6  
7 Nonetheless, there are still financial barriers to access. In the U.S. today it is estimated that some  
8 47 million Americans lack medical insurance; even within the insured population, 61 percent of  
9 adults report being underinsured or having persistent difficulty paying medical bills and out-of-  
10 pocket expenses for prescriptions.<sup>4,5</sup>

11  
12 Unable to afford basic treatment options, an increasing proportion of Americans must resort to  
13 postponing or forgoing required medical treatment and are less likely to receive preventive services  
14 or consistent care for chronic conditions.<sup>6</sup> The escalating prices of prescription drugs and the trend  
15 for employers to avoid providing medical insurance further exacerbate the situation of those  
16 already unable to afford coverage.

17  
18 These financial barriers to care directly affect patients’ well-being. Recent reports by the Urban  
19 Institute<sup>7</sup> and the Institute of Medicine<sup>8</sup> indicate that lack of insurance may directly increase the  
20 risk of mortality in adults by up to 25 percent, and that deaths attributed to lack of insurance have  
21 been rising during the past decade, even when socioeconomic status and lifestyle variables are  
22 taken into account. Inadequate access to health insurance carries significant economic and social  
23 costs as well, including financial risk for families with uninsured members, financial pressures for  
24 health care providers and institutions that serve vulnerable communities, and lost workforce  
25 productivity for employers.<sup>9</sup>

26  
27 Financial obstacles to medical care may also diminish physicians’ ability to use their professional  
28 knowledge and training to care for their patients. Modern medical care often requires more than a  
29 visit with a physician, and a patient without economic means to obtain needed tests, medications,  
30 or therapy can receive less than optimal medical care because of this. It is essential that physicians  
31 address financial barriers to access. How can physicians—and the medical profession as a whole—  
32 best meet the ethical imperative envisioned by the statement, “a physician shall support access to  
33 care for all people”?<sup>3</sup>

34  
35 **OBLIGATIONS TO PROMOTE ACCESS TO CARE FOR INDIVIDUAL PATIENTS**

36  
37 The profession of medicine is grounded in the universal human experience of illness and in the  
38 encounter between patients and the physicians who offer them hope of healing.<sup>10</sup> The moral  
39 relationship of trust and fidelity between patients and physicians that is central to health care gives  
40 rise to special obligations for physicians, including obligations to benefit the patient and to  
41 prioritize the task of healing over other interests. In its turn, the obligation of benevolence sustains  
42 a professional responsibility to take action to help ensure that patients receive needed care. The  
43 obligation of benevolence extends even to forgoing some measure of financial compensation in the  
44 interest of supporting a patient’s access to needed care.

45  
46 Medical knowledge is created and transmitted collectively; physicians’ knowledge and skills are  
47 not solely their own, proprietary goods.<sup>11</sup> As a stakeholder in the creation of knowledge and the  
48 education of medical professionals, society has a legitimate claim on physicians’ knowledge and

1 skills and may reasonably expect them to help ensure access to health care, both as a social good  
2 and to meet the needs of individual patients.

3  
4 There are several actions physicians can take as individual professionals to reduce or eliminate lack  
5 of access for their patients who cannot afford to pay for needed care out of pocket. For example,  
6 Opinion E-6.12, “Forgiveness or Waiver of Insurance Copayments,” (AMA Policy Database)  
7 encourages physicians to forgive or waive copayments when these create a financial burden that  
8 prevents patients from seeking needed care.<sup>12</sup> Similarly, while preserving their right to choose  
9 whom to serve,<sup>11</sup> physicians can opt not to turn away prospective patients who lack insurance  
10 coverage and accept new patients regardless of coverage. In recognition of their obligations of  
11 fidelity, physicians can continue to see existing patients who lose their insurance. Physicians can  
12 further honor the significant societal contribution to their knowledge and training by providing care  
13 for indigent patients at reduced or no charge. Additionally, physicians are in a position to provide  
14 needed services by ensuring sufficient emergency department coverage. This can be crucial to the  
15 extent that many who have insufficient access to care first seek it in the emergency setting.

16  
17 The Council recognizes that individual physicians and groups are limited in their ability to  
18 financially support increased access. Certainly, physicians should not risk the viability of their  
19 practices or the quality of care for their patients overall in order to provide greater access to care.  
20 As one recent commentary noted, “[i]f physicians do not charge for services, they cannot survive.”  
21 Yet as the commentary also noted, “If patients cannot afford those services, they cannot survive.”<sup>12</sup>  
22 When it is not feasible to provide care at no or reduced cost to the patient, individual physicians  
23 can still aid patients in other important ways.

24  
25 For example, physicians can honor their ethical responsibilities to promote access to medical care  
26 by acting as advocates to help patients obtain needed care when patients cannot do so by  
27 themselves.<sup>13</sup> It will not always be apparent which patients face financial barriers to care—and  
28 many patients will be hesitant to raise concerns about cost of care with their physicians. Thus  
29 physicians should routinely inquire about patients’ financial concerns and assist patients to access  
30 public or charitable programs when appropriate. To provide this assistance, physicians should  
31 familiarize themselves and their staff with locally available charitable resources, as well as  
32 industry- or government-sponsored programs designed to help patients who are unable to purchase  
33 medical care or prescription drugs.

34  
35 Finally, in keeping with Principle IX of the *Principles of Medical Ethics*, it is essential that  
36 individual physicians take an active role in public debate about policy solutions to mitigate  
37 financial barriers to access, including the expansion of public medical programs and other  
38 programs designed to solve many of the problems that lead to financial barriers.<sup>14</sup>

#### 39 40 BEYOND INDIVIDUAL PHYSICIANS’ RESPONSIBILITIES

41  
42 Action by individual professionals can help meet the needs of identified patients, but in itself this is  
43 not enough. Simply relying on the charity of individual physicians is neither a viable nor a fair way  
44 to address financial barriers to care—individual action alone cannot address problematic variations  
45 in access to care and risks disproportionately burdening physicians who are in a position to respond  
46 voluntarily to the medical needs of the uninsured. Eliminating financial barriers to care requires  
47 participation from all stakeholders in health care, including health care facilities, health insurers,  
48 and professional medical societies and organizations, to advocate for resources for individuals in  
49 need of medical care.

1 *The Medical Profession*

2

3 Collectively, the medical profession should work to ensure that societal decisions about the  
4 distribution of health resources safeguard the interests of all patients and promote access to health  
5 services by patients who belong to socially, economically, or otherwise medically disadvantaged  
6 groups.<sup>14, 15</sup> The profession should participate in the policy development process by supporting  
7 proposals that will benefit patients and are consistent with the ethical principles on which the  
8 medical profession is established.

9

10 Physicians should also recognize that as professionals they share responsibility to help one another  
11 address financial obstacles for patients in their individual practices. Declining referrals for patients  
12 who have limited insurance coverage or ability to pay adversely affects not only individual  
13 patients, but the professional community as well. When physicians cannot rely on consultants to  
14 deliver needed services they may feel they must provide the care themselves, which may not be in  
15 the best interests of patients or of the medical profession as a whole.

16

17 *Health Care Facilities & Payers*

18

19 The entities in the best position to remove financial barriers to access to care may be those that  
20 most greatly affect the cost of care: health care facilities and managed care plans or other third  
21 party payers. Hospitals account for nearly a third of health spending and insurers, including  
22 managed care entities, account for nearly two-thirds of private health expenditures.<sup>17</sup> Although one  
23 of the primary duties any corporation holds is to its shareholders, an organization providing or  
24 funding health care must also realize how its decisions can affect the health and livelihood of  
25 individual patients. Recently, increased scrutiny of the practices of insurers<sup>18</sup> and health facilities<sup>19</sup>  
26 has heightened public awareness of the role these entities play in access to health care.

27

28 Physicians, even when they are not decision makers in hospitals and insurers, can still exercise  
29 their influence as clinical leaders to encourage these organizations to use their resources to improve  
30 access to care. Further, those physicians who are employed by or otherwise involved with these  
31 entities should remember their ethical obligations regardless of whether they are directly providing  
32 medical services.<sup>20</sup> The well-being of patients should always be the foremost obligation of  
33 physicians, health facilities, and insurers.

34

35 *Public Policymakers*

36

37 For decades, the federal and state governments have assumed large roles in ensuring that  
38 individuals' access to care is not inhibited by lack of ability to pay. However, even with Medicare,  
39 Medicaid, SCHIP, and other public programs, millions still do not have sufficient access to care.  
40 Public programs should fairly distribute available resources to those in need.<sup>21</sup> Specifically, the use  
41 of public funds should be appropriately targeted to benefit patients on the basis of medical and  
42 financial need.<sup>22</sup> While programs that directly assist individuals in accessing care are certainly  
43 appropriate, other programs that can address underlying causes of poverty (such as education,  
44 health literacy, discrimination, etc.) are also necessary and should be considered as part of any  
45 solution to the problem of access.

1 RECOMMENDATION

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3 The Council on Ethical and Judicial Affairs recommends that the following be adopted in lieu of  
4 Resolution 704 (I-07), and that the remainder of this report be filed:

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6 Health care is a fundamental human good because it affects our opportunity to pursue life  
7 goals, reduces our pain and suffering, helps prevent premature loss of life, and provides  
8 information needed to plan for our lives. As professionals, physicians individually and  
9 collectively have an ethical responsibility to ensure that all persons have access to needed care  
10 regardless of their economic means. In view of this obligation:

11

12 (1) Individual physicians should take steps to promote access to care for individual patients,  
13 for example—and when possible—accepting new patients regardless of insurance  
14 coverage and maintaining patient-physician relationships even after a patient loses health  
15 coverage.

16

17 (2) Individual physicians should help patients obtain needed care through public or charitable  
18 programs when patients cannot do so themselves.

19

20 (3) Physicians, individually and collectively through their professional organizations and  
21 institutions, should participate in the political process as advocates for patients (or support  
22 those who do) so as to diminish financial obstacles to access health care.

23

24 (4) The medical profession must work to ensure that societal decisions about the distribution  
25 of health resources safeguard the interests of all patients and promote access to health  
26 services.

26

27 (5) All stakeholders in health care, including physicians, health facilities, health insurers,  
28 professional medical societies, and public policymakers must work together to ensure  
29 sufficient access to appropriate health care for all people.

30

31 (New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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